Information Exchange Workgroup
Draft Transcript
September 13, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning and welcome to the Information Exchange Workgroup. This is a federal advisory committee, so there will be opportunity at the end of this hour for the public to make comments. Workgroup members, if you would please remember to identify yourselves when speaking.

Let me do a quick roll call. David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Faulkner? Carl Dvorak?

Carl Dvorak – Epic Systems – EVP
Carl Dvorak is attending. Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Connie Delaney? Gayle Harrell? Mike Klag?

Mike Klag – Johns Hopkins Bloomberg School of Public Health – Dean
On the call, yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Harley Geiger here for Deven McGraw.

Harley Geiger – Center for Democracy & Technology – Staff Counsel
I'm here. Yes. Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Charles Kennedy?

Charles Kennedy – WellPoint – VP for Health IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman?

Paul Egerman – eScription – CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Dave Goetz? Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steve Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Seth Foldy?

Seth Foldy – Wisconsin – State Health Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Buehler?

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Walter Suarez? David Ross?

David Ross – PHII – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Hunt Blair? George Oestreich?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Donna Frescatore? Jess Kahn?

Jessica Kahn – CMS – Project Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Farzad Mostashari? Paul Tang? Kory Mertz?

Kory Mertz – NCSL – Policy Associate

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Jenkins?

David Jenkins – ACF/HHS – Senior Privacy Official
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Arien Malic? Did I leave anybody off? Okay. With that, I'll turn it over to Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Welcome, everyone, to the information exchange workgroup. I'm Micky Tripathi. I'm the co-chair with David Lansky of the workgroup, and we're delighted that all of you could join us. We have a little bit of a change in the original agenda for the workgroup where the original agenda was to have a full workgroup meeting, but now that we're digging in a little bit into the provider taskforce work, as we'll describe in this, we're going to have the full workgroup meeting meet for an hour to talk about public health and to talk a little bit about the provider taskforce work plan in anticipation of presenting to the HIT Policy Committee tomorrow just where we are on public health and the provider taskforces and presenting the work plans. Then we'll have a separate closed meeting to dive into some of the provider taskforce work related to the upcoming hearing that we'll describe.

What we'd like to do, I'm looking at the agenda on slide two, is for the health information exchange workgroup, talk about the public health taskforce, and really spend, I think, a majority of the time on that to really get the workgroup perspective on what we ought to be thinking about with respect to the public health taskforce so that we can get that underway. And then provide an update on the provider directory taskforce, which is really sort of going full blazes here and is a pretty significant activity that we're going to have over the near term.

So before we launch into that, let me turn it over to David Lansky to see if he has any introductory thoughts.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Micky. Thanks for your leadership in getting us to this point, and thanks, everybody, for getting on the call. The main thing I'd just emphasize, I guess, is we all realize that there's a lot of time pressure, and we all have a sense we want to provide some kind of useful guidance to ONC and to practitioners and to the states in particular as rapidly as we can this fall. So I think we have a challenge, as we go through this, to kind of calibrate how deep a dive we get into some of the granularity and the tactical specifics that we all know are really difficult and important and how we find the right level of policy breadth that we can provide some useful guidance in a rapid timeframe. So I think both on the two topics we're looking at today, the provider directors and the public health issues, we want to understand from you all and try to consolidate our thinking about what can be done to provide appropriate levels of guidance and uniformity, as these programs roll out, and what can we very appropriately and realistically leave to states and practitioners to deal with within some broad guidelines.

So I hope people will find a way, as we talk, to calibrate that. Give us enough specifics and granularity to be sensible in what we talk about, but also not try to solve every problem and cross every T because we obviously don't have the time to do that. I think as you look at your own work and your colleagues, what's the resource or solution that we can help ONC provide to you and to those in the field in the next couple months, two to six months let's say, that would really provide a lot of value.

So that's just my kind of hope for how we think about our products going forward. Thanks. Micky, I'll hand it back to you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

David, thank you for those remarks. I think it is very important for us to just keep at the forefront here, as we think about the agenda, which is sort of a challenging set of issues. But on the other hand, the meaningful use stage one qualifying periods are right here in front of us. So we've got hundreds, thousands, hundreds of thousands of providers and provider organizations across the country who are eager to move forward with respect to meaningful use in stage one meaningful use and being able to accomplish that.

So what we, I think, need to be focused on is trying to remove as many barriers as we can to having achievement of those objectives, not because it gets the money flowing, but because meaningful use is intrinsically connected to improving the quality, safety, efficiency, and affordability of care. So I think that as challenging as these issues are, remaining true to that focus and trying to do whatever we can in the time period that we have to eliminate those barriers and enable the market to respond as quickly and rapidly as possible to this hopefully growing demand from the provider community I think is something we need to remain focused on.

Let's turn to public health. Before we launch into this, I should say that we have trapped, I mean, engaged the volunteerism of two individuals who have agreed to be the co-chairs of the taskforce, but we were just able to press them into action in the last couple of days, so I don't want to put them too much on the spot here, but Jim Buehler from CDC and Dave Ross from the Public Health Informatics Institute have both graciously agreed to be the co-chairs, and we are just delighted that they are willing to do this for us and will help us shape and drive what we're able to do with respect to public health going forward. We have, I know both Jim and Dave are on the phone.

We have a few slides just to tee up this conversation, but really the idea here is these are sort of high level categories of things that we think are quite important, as we start to dig into the public health work ahead. And what we'd like to do is kind of introduce these topics and have an open discussion among the workgroup to get your advice and guidance on how the taskforce ought to proceed going forward with respect to thinking about its work plan, what it should set in terms of priorities and things that they might be able to meaningfully accomplish in this time period with respect to public health.

I would just offer the one reminder about why public health is on our agenda. The reason that it's on the agenda is because it is a critical, meaningful use requirement for stage one. It's a part of the menu set, so provider organizations, eligible professionals, and hospitals do get to choose among three public health transactions that they need to demonstrate the capability of being able to perform, but they are required to do at least one. So public health is really at the forefront of being able to accomplish meaningful use stage one, and it's relevant to the health information exchange activities that are going on in each of the states that are now starting to get underway with the submission of strategic and operations plans. Hopefully the ongoing approval of those plans so that the money can begin to be drawn down and spent on health information exchange activities to support meaningful use. But it's also incredibly important to the regional extension center work that's out there because as regional extension centers now something like 60 of them out there in the field are working to get eligible professionals to meaningful use, a critical part of that is being able to fulfill the public health piece of that.

We're struck by the heterogeneity out in the market in public health capacity across the states at a time when public health funding has been flat or decreasing in some areas, so the challenge is that, in principle, there's going to be increased demand for public health electronic functionality specifically focused on these meaningful use transactions, which are immunization reporting, reportable conditions reporting, and syndromic surveillance. So at a time when there will be hopefully increasing demand for those types of transactions, you have a very heterogeneous public health landscape out there that's very decentralized, and also at a time when funding has been decreasing to public health organizations, state public health organizations. So their capacity to be able to respond to this could be a challenge. That's sort of the backdrop here of why we're engaged in public health as a key area that we can hopefully provide and think of as a breakthrough area.

Let me pause here first and see if Dave Ross or Jim Buehler wanted to say anything at this point, and then perhaps we can just dive into the discussion.

David Ross – PHII – Director
It would help me to know who among the subcommittee is actually on the public health taskforce. I hate to say I'm unclear exactly who among the larger group we'll be working with as a taskforce.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sure. That's on slide six, Dave, but I can just tick off the names, and one of the things that we do on that slide is tee up a call for additional volunteers. But right now it's you and Jim, Deven McGraw—I should name the organizations—Deven McGraw from the Center for Democracy and Technology, Jonah Frohlich from California Health and Human Services, Steven Stack from the AMA, George Hripcsak from Columbia University, Seth Foldy from DHS Wisconsin, who I believe is soon going to be with the CDC, and then finally Walter Suarez from Kaiser Permanente.

Jessica Kahn – CMS – Project Officer
I think at CMS we wanted to have someone involved as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great. Thank you.

David Ross – PHII – Director
I think there's one conceptual thing that everyone should keep in mind when we talk about the public health challenge here. Public health, as we can see from the three meaningful use objectives, mixes two complete, in my view, completely different concepts. One is the concept of those things that public health does that are person centered, so immunizations for example, fits in the same model of individual data related to, at least at the provider point of view, a patient provider interactive, so information to support a personal patient care decision. Similarly, the electronic lab reporting is person specific data.

Then the surveillance issue brings in the population challenge, which is itself another concept, and I only bring this up just to try to make sure everybody thinks about it when we talk about surveillance. The information view is really one of how do I get enough information to paint a picture of a phenomenon, a disease, outbreak for example? Understand it in enough granularity and enough geographic specificity that actions can be taken that will lead to its remediation. That's a way of thinking about this. Not to say that we wouldn't ever want to go back and find specific people and interact with them, but I think I raise this simply to point out that there is an issue of how much data do we need in public health, and what would we do with it, which is raised when we talk about population level surveillance, and is not raised when we're talking about individually based information like immunizations for example.

I suppose as far as this discussion this morning, what Jim Buehler and I talked offline after the meeting/call we had with Micky and David, we'll try to go around, get everybody's thoughts, perceptions about what needs to happen. We can start to structure the work plan for the public health taskforce.

Paul Egerman – eScription – CEO
One of the things I don't understand about public health in terms of the surveillance and the individual data is what is mandatory by state law and what is optional. Can you comment on that?

David Ross – PHII – Director
Jim Buehler, do you want to do that?

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Sure. I'd be happy to take a stab at that. So the authority for mandating or enabling or authorizing public health surveillance and disease reporting is a state level authority and that's handled in a variety of ways. One is the traditional model of notifiable disease reporting where there is a specified list of diseases. Historically those have been mainly infectious diseases, but increasingly you see more categories of disease falling under that. They are specifically designated as notifiable, meaning that individual laboratories or physicians or others are required by law to report those cases to the health department or to allow the health department access to the data to get that.

There are also additional authorities that might mandate reporting of unusual events or suspect disease outbreaks, things that might not be on that list per se, but where there's reason to believe that a public health threat exists. Then, beyond that, there are more general authorities to conduct this surveillance that may not require that individual level of information. So basically disease surveillance or other forms of surveillance is meeting the needs of various public health programs and it might involve analyzing secondary analyses of existing databases like a hospital discharge database, or it might involve doing a telephone survey. Or with this newer domain of syndromic surveillance, it involves connections between healthcare institutions.

Typically it's been emergency departments, but not exclusively where a relatively limited amount of information is collected on an ongoing basis to scan broadly for a variety of potential unusual trends. So it's a very diverse set of functions that arise from the need to meet information for specific public health programs or objectives, and that typical paradigm of notifiable disease reporting is probably the foundational paradigm, but it's certainly not the only approach that public health agencies use to monitor trends in disease or health patterns in the community. But I think Dave hit the nail on the head in saying that some of those systems require individual level data because there may be a need to followup back to the individual patient, but those data also get aggregated up to pain a community wide picture. Other systems may not. They're drawn from individual level data. They may require the transmission of individual level data, but they're really used for the purpose of sort of aggregate trend monitoring.

Paul Egerman – eScription – CEO
My question was from the provider standpoint. I get the sense that generally the infectious disease reporting is mandatory, and I'm also taking a guess that for some of these surveillance issues, reporting is not mandatory.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
It's authorized. In other words ….

Paul Egerman – eScription – CEO
It's authorized, but it's not required.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Yes. Right. I would broadly say that the notifiable disease reporting is a category of public health surveillance. There is a variety of ways that that may be done. It may be, for example, monitoring trends in birth certificates if you're interested in maternal and child health, or it might be monitoring trends that are available from death certificate data if you're interested in mortality due to a particular condition. So there's a variety of sources that public health has the authority to use for that purpose.

Seth Foldy – Wisconsin – State Health Officer
I think it's reasonable also to note that what may be mandatory or mandated at the state level is … concept from what might be required to get meaningful use incentive so that the one is not absolutely required for the other.

Paul Egerman – eScription – CEO
Right. Meaningful use is itself an optional program. I just think the distinction between mandatory reporting and authorized reporting is an important one to keep in mind.

Seth Foldy – Wisconsin – State Health Officer
Absolutely. I had a question regarding the taskforce in terms of the hierarchies of concept. This is the public health taskforce of the HIE workgroup of the policy committee. Many of the concepts on the slide relate to things that might be point-to-point transmission of information as opposed to the use of health information exchanges to mediate that information exchange. I was a little unclear whether the taskforce is actually expected to look both at the use of health information exchanges and other means of transmission, if you will.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. That's a great point and one that we are always coming back to in this workgroup to remind everyone of what the name implies. The name is really about the verb, meaning the name of the workgroup, meaning that health information exchange, the verb, is what we are about here. So we're about interoperability. One instantiation in the market are health information organizations that can help the broker remediate health information exchange activity, but that's just one way that that can happen in the market. Our perspective as a workgroup is broader than that. It's about how to facilitate health information exchange generally, regardless of what approach is taken regardless of its particular instantiation in the market.

Seth Foldy – Wisconsin – State Health Officer
Verb, not noun, that's a great way to describe it. Thank you.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
If I just may add another general comment in addition to the general comments that Dave made, I would say that public health is very eager and interested in being a part of this conversation and really welcomes the notion of having the population health parts to meaningful use because, given this mandate to do disease surveillance or … authority to do that and given the general trend towards automation, and not just of healthcare information systems, but public health information systems—this is a fantastic opportunity to move that conversation forward.

I think the point that has been emphasized about state health departments being at different levels to me raises the policy issue of how do we develop policies or guidance that allows states at different levels of capacity to be successful. These three population measures are activities that have a different history and level of development. Immunization registries have been around for a fairly long time. That interaction between clinicians and public health around immunization registries is relatively well understood, at least by those providers that provide a lot of vaccines, particularly to kids. ELR, the electronic laboratory reporting, is a key component of the notifiable disease enterprise. Again, I think that's something that's relatively familiar that the role of public health and infectious communicable disease control.

The syndromic surveillance piece is a slightly different animal, both conceptually, as well as where it's at in terms of practice. States are at varying levels of capacity or development in terms of using that. In some states, it's more local health departments that are in the forefront of that. In others, it's a shared model. It has tended to be something that's done in collaboration with more defined networks of providers so that that syndromic surveillance enterprise is a piece that may be less familiar to the provider community than the other two.

But what I would see, to me, one of our goals is to develop policies that lets states be successful, that recognizes the variability, the different levels of capacity they have, and allows them to sort of focus their work in this domain at a level that they can make it work, which may mean that the breadth of providers or the scope that are engaged, particularly from the syndromic piece, may be variable from one state to the other. I also say that a key issue is really that we ought to be thinking strategically about what are the future population health measures that would be part of meaningful use and how do we develop a strategy or a set of principles that would articulate how we would go about selecting those.

Charles Kennedy – WellPoint – VP for Health IT
I just want to reinforce those points. I had a chance to give a speech on health IT to a coalition of public health officers from throughout the state of California, and I was rather surprised at the feedback. The feedback was don't think of us narrowly in kind of the traditional world of public health as you do this. Please think more broadly. The area they asked me to consider and reflect to the group, which I'm doing now, is things like chronic disease management and assessments of that at the population level. So at least I can share one data point with you that public health offers in California would strongly agree with what you just said.

David Ross – PHII – Director

Yes. I want to reiterate, I've heard that from … our interactions with the colleagues that we work with in public health around the country. I think meaningful use, to me, the exciting part of this concept is meaningful. Underscore that word because just like a data point like the temperature is 90 degrees is nice. What's very helpful to everybody is understanding the entire weather forecast. Public health has the opportunity, if we all do this well, over time, to put a large perspective on what trends are happening, as well as using the information to come up with suggested different kinds of intervention, help understanding whether the health system investment overall is really achieving what we want out of it. So I think that ought to be one of the pieces, goals of this workgroup or this taskforce is to assure that we do look broadly.

M
Right.

Charles Kennedy – WellPoint – VP for Health IT
And clearly, if you look at what are the leading causes of premature morbidity or premature mortality and morbidity, many of those are chronic diseases and, for many of them, the interactions that occur between the doctor and the patient in terms of primary prevention or screening or secondary prevention in terms the care of patients with those chronic diseases. If that happens effectively, that's going to improve. That's going to have a public health benefit. Yes, clearly public health is very interested in the chronic conditions.

Mike Klag – Johns Hopkins Bloomberg School of Public Health – Dean
I just want to make the comment too that it's important to monitor chronic disease, not only to gauge what happens with providers and patients, but also because, at the policy level, we need to attack the underlying causes of chronic disease. You probably saw the recent IOM report about hypertension and how we need to have national policies to change the way we eat. The only way we're going to know whether those public health interventions are effective is if we monitor chronic disease status and risk factors.

M
Yes. I would agree.

M
Micky, we're going to talk on this subject for what, another 30 minutes?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
No. Actually, I was just going to talk about that. We want to talk to the full workgroup a little bit about the provider directory plan ahead as well, so we want to leave some time in. Of course, this is a public call, so we need to leave a little bit of time at the end also for the public, any members of the public who would like to comment as well. What I was going to suggest is perhaps another 10 to 15 minutes at most of discussion that perhaps drilling down a little bit into some of these categories to get some feedback from the workgroup that might help you in the development of the work plan. Does that make sense?

M
Yes. That sounds good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
One of the things that strikes me—and I can just kick this off is, as we think about—I'm on slide three here, looking at the public health taskforce—there are just a few slides, so we don't have to dive down deep into any of them. This one has these four categories that we talked about. The next slide, slide four, just reiterates what is in the final rule with respect to public health, just so everyone has that for documentation. Then on slide five, just really sort of teased up a little bit of sort of the scoping that we want to think about here, which is what problems are we trying to solve?

One is about enabling stage one, meaningful use stage one, population of public health objectives. So I think related to this conversation we were just having about a broader and more expansive and probably

more societally beneficial perspective of public health. This is very similar to some of the other activities like provider directories and others where we want to say, how do we focus in on the stage one meaningful use requirements with an eye toward building something that is going to be extensible and that can be something that can be expanded upon going forward for the greater needs that we know, and some of which we just don't know.

With an eye toward that, just going back and thinking about these four categories with respect to meaningful use, and we've talked a little bit about that now, about what these requirements are and perhaps being able to give a little bit of insight into that as the taskforce thinks about it. Are there issues around definition? Are there issues, other issues that we don't know about that we should be thinking about? The second is about the standards harmonization and adoption, the final rule, both the meaningful use final rule, as well as the standards final rule in the certification requirements on electronic health records all have standards related to public health in them. Certainly if there is a sense among the taskforce, and ultimately among the workgroup here, that we need more there or less or something different, that would certainly be an area for discussion.

Then, finally, the third bullet on the public health capacity platform, one of the things that we talked about earlier this morning in an organizing call is just this question of the environmental scan, understanding the landscape out there, and that that perhaps could be a significant first value that we bring to the public here is just some kind of landscape picture that shows what the state of our public health capacity is and would certainly love to hear your perspectives, Jim and Dave, and also the workgroup's perspective on whether that would be beneficial and what might be ways of getting at that because our understanding is that the CDC may have some information on that, but perhaps not as much information as we might all want to have, and are there strategies that we might think of for trying to pursue that.

David Ross – PHII – Director
Yes. I think my two cents on doing the environmental scans or painting the landscape is that it's a very important task. It gives the committee the opportunity to have some confidence in understanding the perspective with which we come forward with some recommendations. I think that's an important first task.

We know that ASTHO and NATCHO have both done some degree of surveying, some— I'm cautious here because assessing the public health infrastructure is very difficult, given the highly decentralized way public health is organized in the U.S. But I think, trying to paint that picture as accurately as possible early on would be important. I wonder if any of those of our colleagues on the phone like Seth Foldy or Jim Buehler, who are involved in public health practice, would have any similar comment.

Claudia Williams – ONC
I just want to offer a thought here. I think this landscape obviously is very nuanced and textured and complex. I think one way to simplify our particular view of it is again to focus on thinking about the HIT public, the sort of HITECH public health interface and meaningful use requirements, both for stage one and stage two, so that we don't try to take on what probably is an impossible task of trying to look at the whole public health infrastructure. My suggestion would be to maybe narrow down the focus a little bit to the sorts of transactions that are envisioned in stage one and the kinds of things we might want to move to in stage two.

Seth Foldy – Wisconsin – State Health Officer
I think what is useful for people to know is there's now an advisory group meeting regularly inside CDC on these topics, but also a group of associations, public health associations that have formed a joint taskforce to look at public health informatics in general, but have made a key and urgent focus getting ready for stage one, year one. And so I think, as these three groups in a sense move forward, this taskforce, the public health taskforce on meaningful use, and the CDC committee, we should be able to figure out who is doing what so that we don't do things two to three times. I think the good news, Jim and I and Dave are involved with at least two of the three. Crosscutting, we should be able to keep our work trails clear.

M
Seth, can you give us a quick update and overview of what information ASTHO does have now and where you see the gaps and how the workgroup at CDC that you will soon be chairing when you join our staff is thinking about approaching that, if that's not getting too far ahead of your current job?

Seth Foldy – Wisconsin – State Health Officer
Right. And I don't have a lot of data in front of me. The ASTHO survey was looking at items like was trying to check in on do you know your state HIT coordinator and other important questions. But the last survey done was done before the release of the latest standards. What we think we need to do next is to do an assessment of how many, in particulr, states, but also in some cases larger local jurisdictions, see themselves as trying to be ready to connect for meaningful use state one during year one.

Which of the different areas of meaningful use they expect to try and have ready in a timely fashion, and which standards they might be planning to implement because, in most of these, as in many of the other meaningful use standards, there's a choice between … about two different standards. That, for the most part, I think we have to see as forthcoming in terms of knowing are we talking about 40 jurisdictions statewide or 10. That's the kind of answer we cannot tell.

What we do know on the state front, I doubt this comes as news to anybody, but it might. There has been immense difficulty as public health funding over the last two years of the recession. And we are now competing also for HIT experienced personnel with the much larger and better paying healthcare sector. So there is some concern about trying to keep the people and the money around these systems to get the job done in the coming year. It'll take a certain amount of creativity to keep us moving forward quickly speaking kind of from the state perspective.

David Ross – PHII – Director
Would you agree with the idea that painting this or doing this environment scan, painting the picture of the landscape as regards to the meaningful use objectives would be a good, useful task of this workgroup?

Seth Foldy – Wisconsin – State Health Officer
I think it desperately needs to be done, and so long as we're not doing what some other group is clearly doing, then yes.

Jessica Kahn – CMS – Project Officer
Yes, that's what I was going to say, which is that the state Medicaid agencies are required, as part of their environmental scan under the state Medicaid HIT plan, to assess their state partner, including public health readiness on these very issues. So state-by-state, we're supposed to be getting this information from them through their plans, which we're paying for the environmental scans.

Seth Foldy – Wisconsin – State Health Officer
I know that, for example, here in Wisconsin, we didn't submit a huge amount of detail on our Medicaid plan. But in a PIN, a requirements notice from ONC, state HIE plans must include a description of how states will incorporate public health meaningful use into their HIE standard, strategic and operating plans. So if it were possible at ONC to do a quick dive and look at what is reported across the states, that may provide rapid information without having to ask twice.

M
Yes.

Claudia Williams – ONC
We're in the middle of reviewing those submissions. In some cases, we have ended up with really interesting detailed information about the capacity. It's variable, I would say, state-to-state. So I think there would still be value in having a super smart, very grounded, public health expert think broadly about the capacities and where some of the gaps are across states, and maybe have us, along with CMS, be able to synthesize the results we're seeing from actual state plans. Maybe then the environment scan could focus sort of one layer up of abstraction and just saying when it comes to this particular MU

requirement, here are the types of issues states are facing and the general strategies they're taking, and sort of the list it's going to require to get from here to there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Is that something that the taskforce can perhaps work offline with you and Jess from CMS to say, as it relates to the meaningful use stage one requirements around syndromic surveillance, reportable labs, reportable conditions, and immunization registries for eligible professionals and for hospitals, being able to develop something that would say state-by-state, here's where they are?

Claudia Williams – Markle ONC
I'm not sure we're going to be able to report it state-by-state simply because the plans are not shareable until they're approved. But I think we could certainly classify sort of the different sort of strategies and where folks are. We'll have to – I'll have to sort of talk to folks here about that.

Jessica Kahn – CMS – Project Officer
Yes, and let's definitely talk offline because we also have a technical assistance contractor whose job it is to mine through the plans for us on our side at CMS to help pull out things that we need.

Claudia Williams – ONC
Micky, that's a very good goal. Let's do it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Okay.

Claudia Williams – ONC
Yes. Like we've done for provider directories, we should be able to help resource. Maybe we have enough current resources even, but we should be able to find a consultant who can work with us on whatever level of analysis we feel like we need in addition to what's already available.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's great. I didn't want to suggest that without—

Claudia Williams – ONC
No, I mean ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
…offline conversations, so I think that's great. I mean, I think it's pretty clear from this discussion that some type of environmental standard is going to be critical because it's very hard for the taskforce and the workgroup to engage in this kind of environment where we just literally don't know what's going on out in the states with respect to their capability to provide the capacity for providers to achieve meaningful use stage one. But appreciate, on the other hand, the difficulty of trying to get that information in a detailed way, so somehow trying to strike that balance so we can get enough information to move forward would be very critical here.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
I agree this is very helpful, particularly in terms of the meaningful use piece. I'm looking at the other three subject headings on slide number three, and wonder if these information resources will provide much perspective on that or if understanding these will require a different kind of input. But I'd be curious to hear from the group, thoughts about some of the other two big issues there, particularly the standards harmonization issue and public health capacity/platform issue.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Since I want to keep up on the agenda, I'm going to take that as no further comment right now. Jim and Dave, if it's okay with you, I think that this has provided some movement forward and some guidance from the group, and I would like to be able to move now to a discussion of the provider directory taskforce, and

also we need to leave some time for the public comment, so unless there are any sort of final thoughts or questions from either of you, is it okay for us to move forward?

David Ross – PHII – Director
Yes. That's fine.

Jim Buehler – CDC – Acting Director, Public Health Surveillance Program Office
Sounds good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, thank you again for your willingness to take this on. We really appreciate it. I don't know. Is Jonah Frohlich on?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I'm here.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Welcome. Thanks for getting up early, relatively early for this. Jonah is with Walter Suarez, who I don't believe was able to make it today, is the co-chair of the provider directory taskforce. There are a couple of slides here, Jonah. Actually, this part of the conversation, I think all of this stuff is stuff that you have participated in, so can I turn this part over to you?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Sure.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great. We're on slide seven, which is just the update.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
The provider directory taskforce has met and convened once. It was actually last week, and I guess I can go through a few of these slides. We've got slides 8 through 12 here. If we go to slide nine, please, this is a little different. The directory taskforce is made up of members both of this workgroup and of others, and it includes both members from state government, organizations and vendors, health information exchanges, etc. There are a number of charges that the taskforce has been assigned to make recommendations on, and those charges include what are the priority uses for state level provider directories or directory services.

If we go to slide nine, please, essentially what we're trying to determine here are what is it that we want these provider directories to do? How do we want them to function? What are the main business services that we believe are necessary in order to facilitate direct exchange and to meet in the immediate term stage one meaningful use goals and priorities, but to have a longer view towards meeting either interoperability goals stage two and beyond, and the needs of our healthcare stakeholders. We need to determine first of all what those priority uses are for, and we say state level, but we also are looking for more expansive notions of directories, which could be multistate, regional directories or greater. So we don't want to limit our thinking to just state-by-state level directories, and we'll be making recommendations on how we can use this opportunity to consider leveraging both the state HIE grants and other opportunities to instantiate these kinds of directories.

Based on what we identify as these priority uses, we want to make recommendations as to what kinds of standards are needed for these directories, both content and potentially architectural standards. What kind of requirements and policies are necessary to enable the creation and sustainability of provider directories or directory services? I think we'll need to look at some of the recommendations that have come out of some of the other workgroups and tiger teams, the privacy and security tiger team in terms of the kinds of privacy policies and standards and other policies, data use agreements, etc., so we may want to be looking at NHIN policies that have been created to date and those that are emerging.

In terms of the requirements and strategies, we need to make sure that the directories, we kind of look at three domains. One is that they are authoritative. Essentially, that they have accurate and up-to-date information, and that this information needs to be accurate in order to enable the routing of health information so that they can be trusted to route to the right location. This will enable a trust framework, which is necessary to insure that we can safely and securely exchange information across our network.

The second is that it's comprehensive. Again, this means that within whatever geographic area these directories operate and if we have federated directories, are able to exchange with each other, that the information contained insures that within a region it is comprehensive. It has the listings of as many providers as it will accommodate, and wants to be a part of the directory.

The third is that they're open and that these directories are available for multiple parties, whether they are the noun, the health information exchange organizations, hospitals, and delivery networks, NHIN Direct users, public health, and others. And that they're used for multiple purposes, whether or not it's for direct exchange of a CCD, of a patient visit summary, whether it's for public health, primary healthcare, and other ways, lab, etc., and that they support obviously interoperability.

Slide ten: The approach that we are taking is to come at it from two angles. One is that we define the use cases, both current and future uses. And, for example, one of the high priority use cases we are going to start with is in patient visit summaries and in exchanging and using directories to facilitate that kind of exchange. And there are others: lab, public health potentially, and others that could use these provider directories, e-prescribing, etc. When we define the use cases, both sort of the high priority immediate use cases, which is stage one meaningful use, but look to the long-term to make sure, for example, that these directories can facilitate query and response kinds of interoperability. We then would want to define the requirements to insure that these directories can actually meet those business or use cases.

Once we have that work completed, we want to insure that we understand what the current on the other side, what the current sources of provider directories are so that we have a landscape assessment as sort of an inventory of what kind of directories exist today whether they're available in healthcare or even beyond and outside of healthcare. And once we have both these use cases, these business requirements, and we have this inventory of existing capacity, both in the public and private sphere, then to facilitate and conduct a gap analysis so that we understand where we need to insure that we can meet the business needs with other available technology and services or to add on additional services to meet the business needs. Through that, we would make the recommendations. That's essentially our framework for how we propose working through the provider directory issues and making recommendations to the policy committee.

We have listed about ten requirements here. These are fairly detailed that we'll be going through, and it gets really just one level deeper in terms of the business requirements, technical requirements, but it really talks about coverage, who is involved in the directories, what do they cover. Are we talking about when we talk about provider? We're not just referring to individual level physicians, but we want to insure that we include those who are those entities that are engaged and need to be engaged in exchange to facilitate stage one, two, and beyond meaningful use, so that includes labs. That includes hospitals and pharmacies, etc. These directories need to be more than just about the individual physicians or what typically are referred to as providers.

Paul Egerman – eScription – CEO
I hate to interrupt, but according to HIPAA, laboratories are providers, so you're using the definition of providers a little different than the HIPAA definition.

W
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Paul Egerman – eScription – CEO
HIPAA has entities as providers.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Understood. What often is confused, and we've been having this discussion in California. When we have used the term provider directory, and the current language that most people understand when they hear provider is physician or nurse. So I totally understand that HIPAA refers to and defines a provider as much broader than that and includes laboratory. What I want to make sure that we as a workgroup understand is a foundation that when we mention provider, we have a more expansive definition of this.

Paul Egerman – eScription – CEO
That's a little different than what the privacy and security workgroup is doing. They're using the HIPAA terminology. Might you want to consider perhaps the terminology clinician instead of provider if that's what you're doing?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
We could, and what we're trying to do is we're trying to avoid— So one of the things we discussed in our first task group meeting is to make sure we have a definition of provider so that we all understand what we're referring to, and that we have as a subpart of provider, as you said, a clinician, to define the individual physician or other ancillary clinician.

Seth Foldy – Wisconsin – State Health Officer
Aren't we really talking about data users and data providers as being in the directory?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Carl Dvorak – Epic Systems – EVP
The thing I think we need to be very careful with is to make sure that the definitions on the directory side are very tightly aligned with the definitions on the privacy and security recommendation side because otherwise it'll simply generate a lot of confusion. I think the privacy and security groups use the HIPAA definition of provider, and it was pretty clear that that meant it could be an organized system of care. It could be a provider group practice. It could be a hospital system as well. So if we could, I think we should have a deliberate step to align those definitions for simplicity later on, or we'll be having to come back to the table and try to arbitrate differences and understanding. I think we can do the country a favor by trying to get those aligned to start with. Secondly, my recommendation would be to use the definitions that were previously used in the privacy discussions so that we can leverage that work to its fullest extent.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Good points.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
I want to make sure we don't lose what is the functionality requirement here though and is that going to be the same?

Paul Egerman – eScription – CEO
I think you can get the functionality … but I think that it's really important that we do what Carl suggested, that we be consistent in our use of terminology. I think when we presented, and I'm co-chair of the privacy group. When we presented, indeed there was a lot of confusion about terminology, and … worked hard to try to educate people on the difference between a clinician, a provider going to HIPAA, and there's a third concept called OHCA, an organized health care arrangement.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Right.

Paul Egerman – eScription – CEO

And that I just think that we need to stick to that terminology. We can't redefine it differently in each workgroup because then … totally confused as to how these different pieces are supposed to fit together, and they probably won't.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
No, I don't disagree. I just want to raise the flag of functionality.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I think that's a great point, and I think this is a great discussion. But I think all we're talking about is making sure that we're using consistent terminology, not about changing the scope of what we're talking about, Dave. I think Paul and Carl's points are very well taken, so we'll, going forward, try to align the terminology to make sure it's consistent with the others.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
On Dave's points, one of the requirements clearly is going to be the business requirements, and we have here listed at the bottom of slide 11, business terms. We don't have a specific breakout here, and we may want to just for the sake of clarity that there need to be a set of clinical business requirements. And I think they're baked into many of these different categories. But we have to very clearly state what it is that we want the provider directories to do, what problem they're trying to solve, and what sort of business use these directories will serve for the intended customers, which in many respect for the clinicians and clinical providers once we get a definition we can agree on.

Charles Kennedy – WellPoint – VP for Health IT
Listen, under business terms, I don't see anything in here about using these directories potentially for administrative claims processing and whatnot. Given the need for these HIEs to find a business model, it might be interesting to see if you had clean, accurate, and well-maintained provider directories, if you could build the revenue flow for some of these folks.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think that is an excellent suggestion, and I would like us to think even a little bit more in that direction when we're thinking about what these directories might do to facilitate the insurance exchange health reform component.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Yes. And we had that. We had that as a separate bullet as uses, Charles. Then, I think, in our reorganizing, we just forgot to sort of fold that under business terms. But the point was there, and I'm glad you reminded us of it.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Good.

M
Amen.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think there's agreement. In terms of content, this is the second bullet on slide 11. What's the type of information that will be needed within the individual or the federated kinds of registries, whatever we end up making recommendations upon? Third, in terms of standards, what standards are needed on the data elements and probably structurally and potentially on the architecture? The fourth is architecture. How should the directory approach be architected? What are the different models? That should flow from our business requirements? The … identify proofing, what level of assurance is needed to insure that we have high use and how will that assurance be provided?

Paul Egerman – eScription – CEO
I'm not sure that's the same thing as identify proofing, however. There's a separate effort that's about to get underway with the privacy group that's going to be called provider authentication, which is really

about, in effect, issuing digital certificates or digital credentials to entities, providers at an entity level, so that you can exchange information confidently. Is that the same thing as to what you're talking about for identity proofing?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
The way I would actually think that what you just described is more in line with what we mean by identify proofing by the language that's here. We do need to have a discussion around things like certificate authority and the responsibility for managing those digital certificates. I think what you just described is probably a better way of denoting what we mean by identity proofing.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I guess the other thing I would say, Paul, is I think here we're talking about requirements areas, so in a way the question is what level of identify proofing would one need for a particular use to make a provider directory work for a particular user.

Paul Egerman – eScription – CEO
So my observation is there's a separate group that's being formed to do this already. Either there's overlap or we need to work through that on this one specific issue.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. We'll need to coordinate on that because this is a pretty critical component of the directories' architecture and structure, so we'll need to make sure that we're coordinated. It's not something that we, in my view, can punt on.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Jonah, can I move us to the work plan just because we're coming to the end of the hour, and we have the public comment period, and we're going to go into a closed meeting to dive down into the directory?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. All right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
In terms of the work plan on slide 12, we had the first taskforce meeting last week. We're having a second one immediately following this call. We'll be presenting taskforce work plans to the policy committee on the 14th. I believe, Micky, you and David will be presenting those. On September 23rd, we'll have another directory taskforce call, and we're going to be focusing on finalizing the hearing that we intend to host on the 30th in Washington. Then we would, within a week, around October 6th, make recommendations and finalize those recommendations and present those to the policy committee on October 20th, and that's it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think just one small caveat that we'll talk about in the taskforce meeting, but while we're in the public meeting, I think probably one of the things that we might want to talk about with the taskforce is given the complexity of what we're addressing here and how many disparate types of directories there are out there and the complexity of just doing an appropriate environmental scan, we may want to think about sort of a phasing or a staging of requirements to the policy committee that maybe focuses on first principles first, and then provides some greater granularity in a next round of recommendations or something like that. But that's just something that I just would ask that in the taskforce meeting that we think a little bit harder about, as we look at these pretty ambitious timelines. Recognizing the urgency out in the market. On the

backend, we don't want to push this out too far because there is urgency in the market, and particularly with all of the state level activities that are going on and the pressing need that they have to move forward.

I believe that, Judy, that concludes this part of the meeting, so let me turn it over to you for the public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, could you open the lines and see if anybody from the public cares to make a comment on this information exchange workgroup portion of the meeting?

Operator
Our first comment is from Fred Bohr with Medi Steward.

Fred Bohr – Medi Steward, LLC
This is Fred Bohr, and my organization is Medi Steward, LLC. I live in McFarland, Wisconsin. I just have a brief comment. My perspective is that from an older American having multiple chronic conditions. I would recommend to understand the public health standpoint that Dr. Foldy make available an issue paper that was produced for the Wisconsin study.

The issue paper is called *Public Health Participation in Statewide Health Information Exchange*. It's dated May 11, 2010. It was produced for the public health workgroup of the state wired board. It was produced by Lawrence … Ph.D., M.S. This issue paper, it's difficult to find because it's on a SharePoint site, but it captures essentially my view as a person, as a consumer, as a patient in terms of public health participation. So I just would recommend that Dr. Foldy make this available to the rest of the workgroup. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Mr. Bohr. Any other public comment? Okay.

I think, Micky, what we'll do now is hang up and then dial back in. The provider directory taskforce will dial back in.

Seth Foldy – Wisconsin – State Health Officer
Seth Foldy will send the document to Judy Sparrow.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you, everyone.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bye-bye.

Public Comment Received During the Meeting

1. FYI: IHE has worked on the Provider Directory issue
http://healthcaresecprivacy.blogspot.com/2010/08/healthcare-provider-directories.html